Common health problems of consumers in methadone programs

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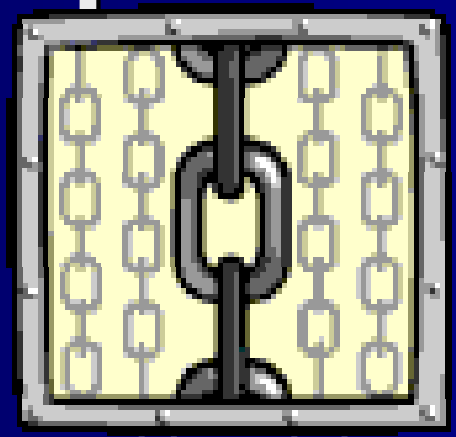
Tips for addiction clinicians, patients with medical problems, outline

- The role of the addiction clinician with respect to medical issues
- Hepatitis C
- HIV/AIDS
- Chronic Pain
- Disability

Addiction clinician's role in medical problems

Information



Making links

Support

Guidance

Clinician's role, concepts

- "no wrong door" and interdisciplinary care
- What addiction clinicians know helps the medical practitioner
- MAT may need modification in certain chronic conditions
- Interventions depend on stage of illness or condition

Hepatitis C: information pp 167-171

- Needle use/blood transmission
- Up to 96% of MMT patients test positive on the screen
- Only 20% progress to cirrhosis
- Treatment of HCV while on MMT is successful
- Liver-protective advice is part of care.

Forearm

Injection Drug Abuse

Shoulder

Abcess postincision and drainage

Injection Drug Abuse

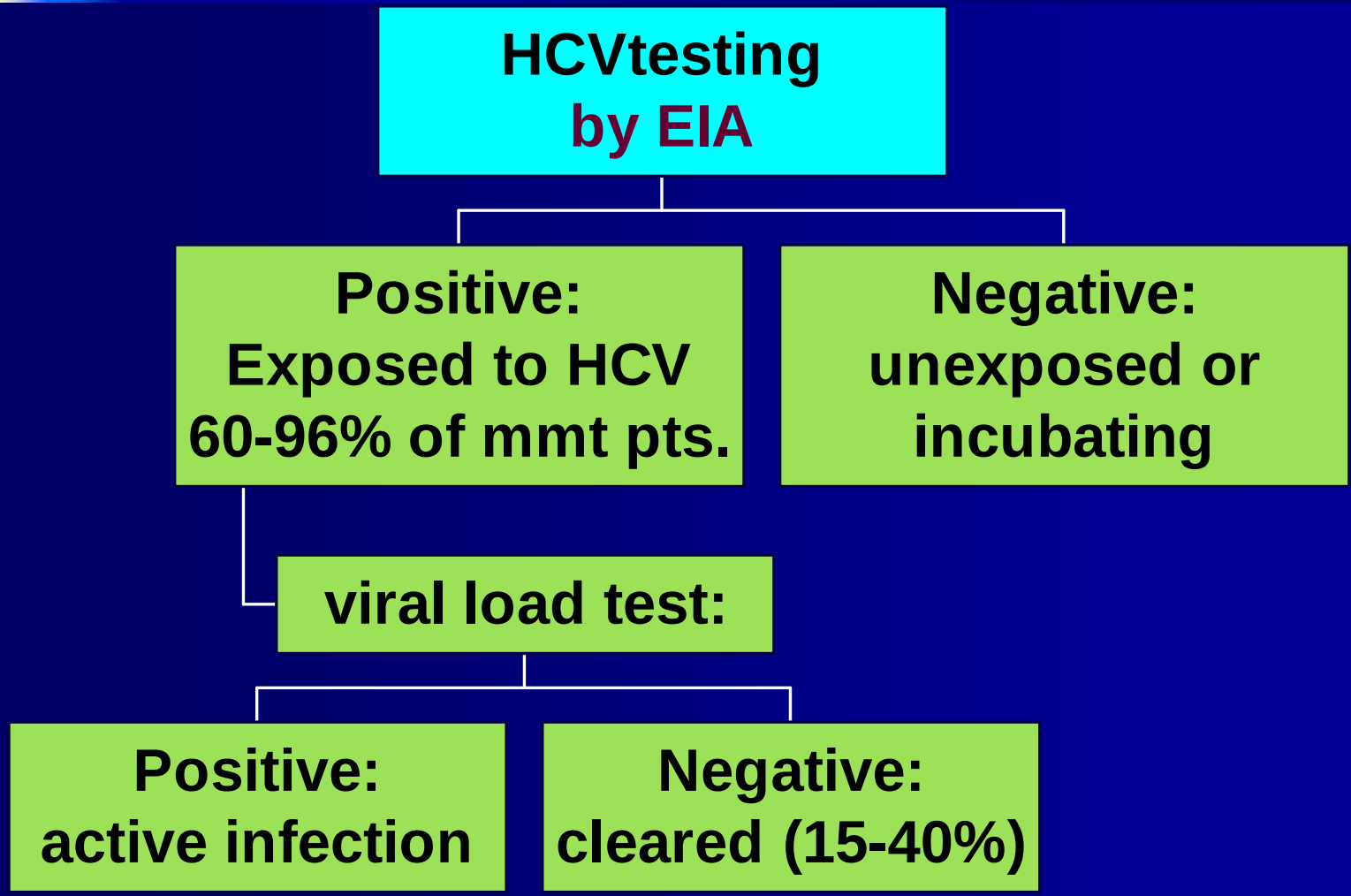
Antecubital Fossa

Injection Drug Abuse

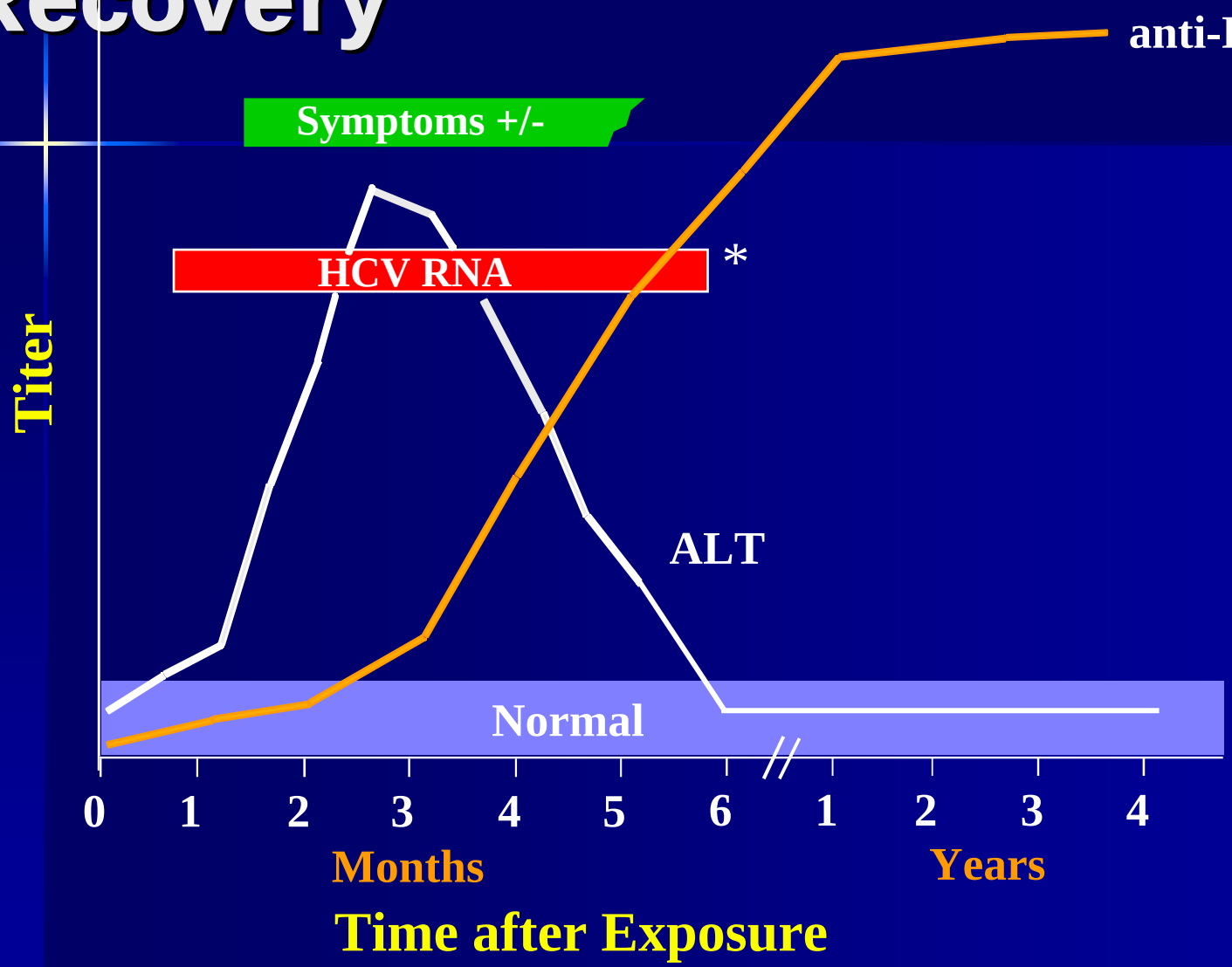
HCV, support and guidance.

- Support screening
- Support further evaluation
- Support during treatment
- Advocate for transplant
- Guidance about liver protection

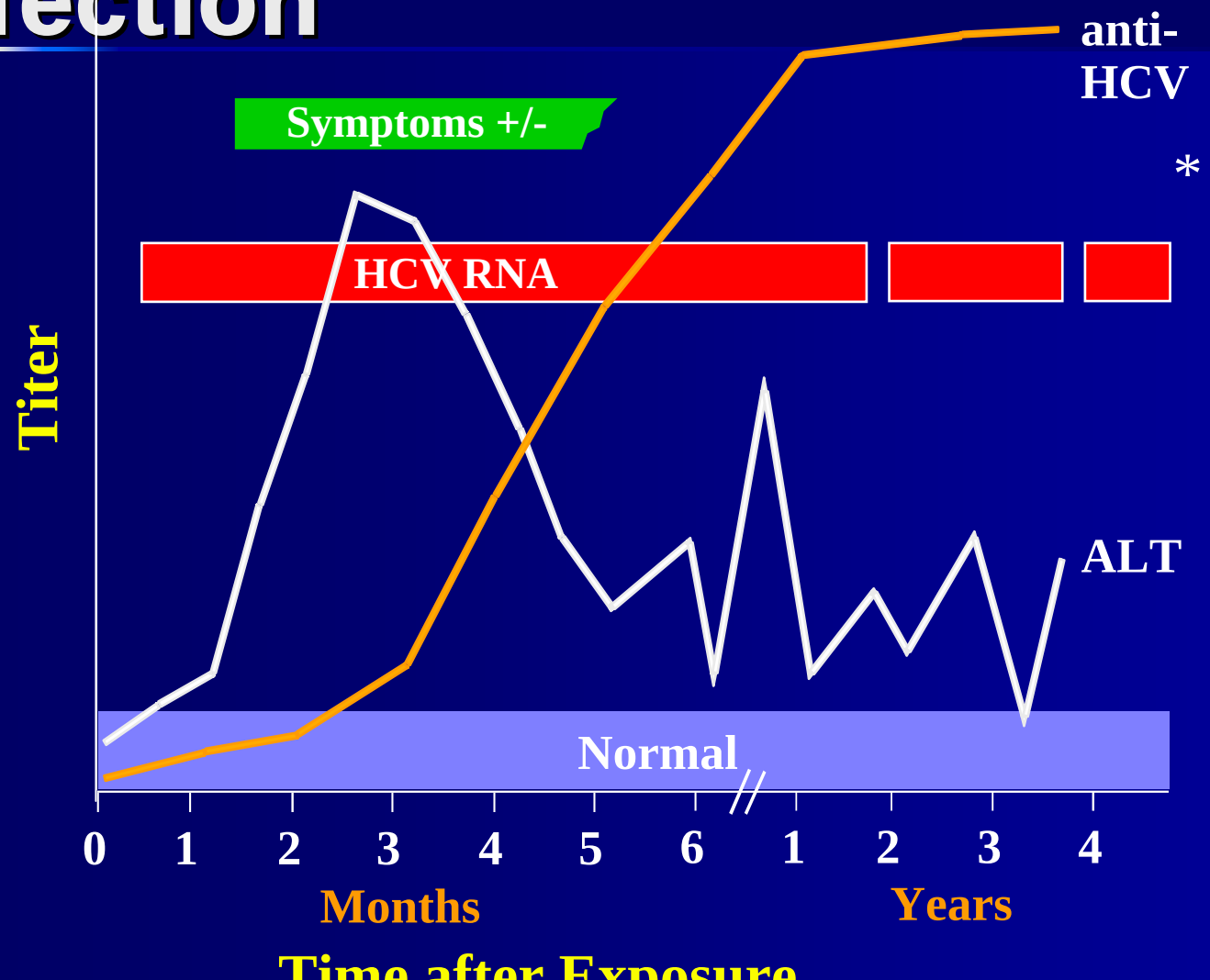
Evaluation flowsheet for HCV: initial steps (p. 169)



Acute HCV Infection with Recovery



Acute HCV Infection with Progression to Chronic HCV Infection



HCV Treatment in Injecting Drug Users

- 2002 NIH guidelines on treatment of HCV
  - Management of HCV-infected IDUs is enhanced by linkage to drug-treatment programs
  - Promotion of collaboration between HCV experts and providers specializing in substance abuse treatment
  - HCV treatment of active IDU should be considered on a case-by-case basis
  - Active IDU should not exclude patients from HCV treatment

Treatment

- Pegylated Interferon/Ribavirin
  - 54 % SVR
  - 1 year treatment,(one injection per week, pills twice a day)
  - Genotype 2 & 3 better response

  than genotype 1

  Non-remitters might require ongoing treatment.

  *remember! Most people with hep C don't need treatment.

HCV treatment: Side Effects

- 20% Cannot continue treatment
- Autoimmune illnesses may flare
- 82% Influenza-like syndrome
- 20% Neuropsychiatric complications
- 5% Bone marrow suppression

Liver-protective advice

- No alcohol
- Limit acetaminophen
- Immunize against A and B if applicable

HCV, patient concerns

- Reluctant to find out
- I’ve got it, but I’m OK
- Biopsy fear
- Actively using
- Relapse if in pain
- Needles will be a trigger
- Transmission to family

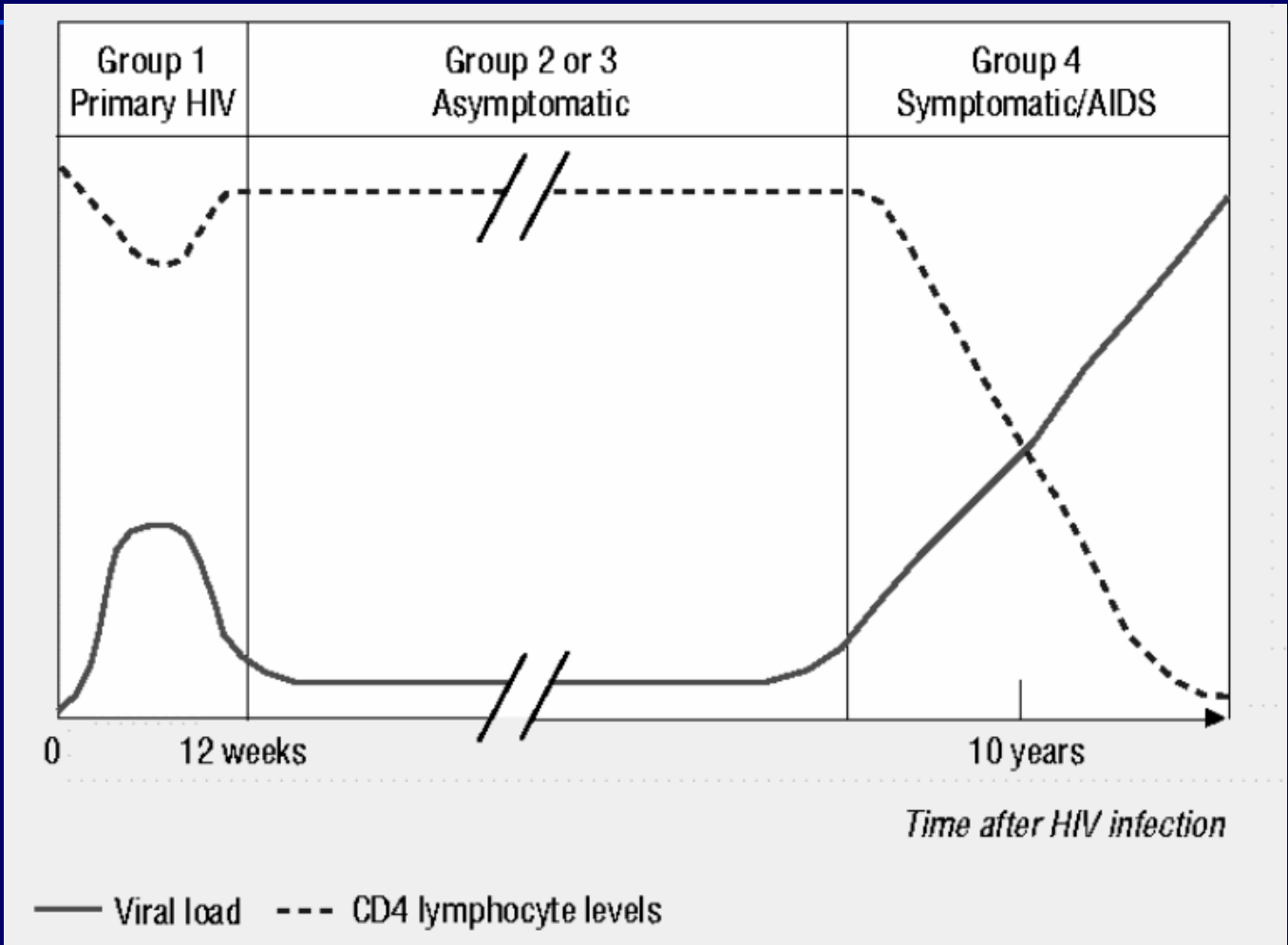
HIV/AIDS, info (pp 171-173, TIP 37)

- World ~58 million cases
  - 15,000 new cases/day
- U.S. ~1.1 million cases
  - 45,000 new cases/year (25% from IDU)
  - **15-20% long-term IDU's infected**
  - 0.7-34% (median 15%) seroprevalence entering substance abuse treatment
  - 43% AIDS in women secondary to IDU

HIV/AIDS, addiction clinician's role

- Encourage testing
- If positive, support adjustment to diagnosis
- Support regular monitoring
- Support adherence to treatment
- Support during end-of-life care

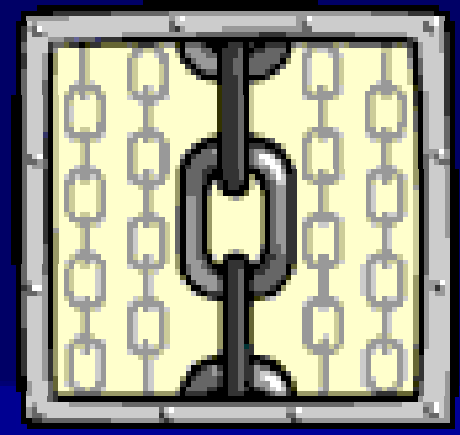
Natural History of HIV Infection: a chronic disease



Stages of HIV-1 Infection

- Viral transmission
- Primary HIV infection (acute HIV infection or acute seroconversion syndrome)
- Seroconversion
- Clinical latent period
- Symptomatic AIDS

Indications for HIV/AIDS Treatment: counselor has key knowledge



Clinical Category	CD4	HVL	Recommendation
Symptomatic AIDS	Any Value	Any Value	Treat
Asymptomatic AIDS	<200	Any Value	Treat
Asymptomatic	>200 but <350	Any Value	Treatment Offered Controversial
Asymptomatic	>350	>55,000	Controversial 3yr risk >30%
Asymptomatic	>350	<55,000	Defer Treatment, 3yr risk <15%

HIV treatment, at least 3 drugs

Medication classes available:

a) Reverse transcriptase inhibitors (e.g., Zidovudine or AZT)

b) Non-nucleoside reverse transcriptase inhibitors (e.g., Efavirenz or Sustiva)

c) Protease inhibitors (e.g., Indinavir or Crixivan)

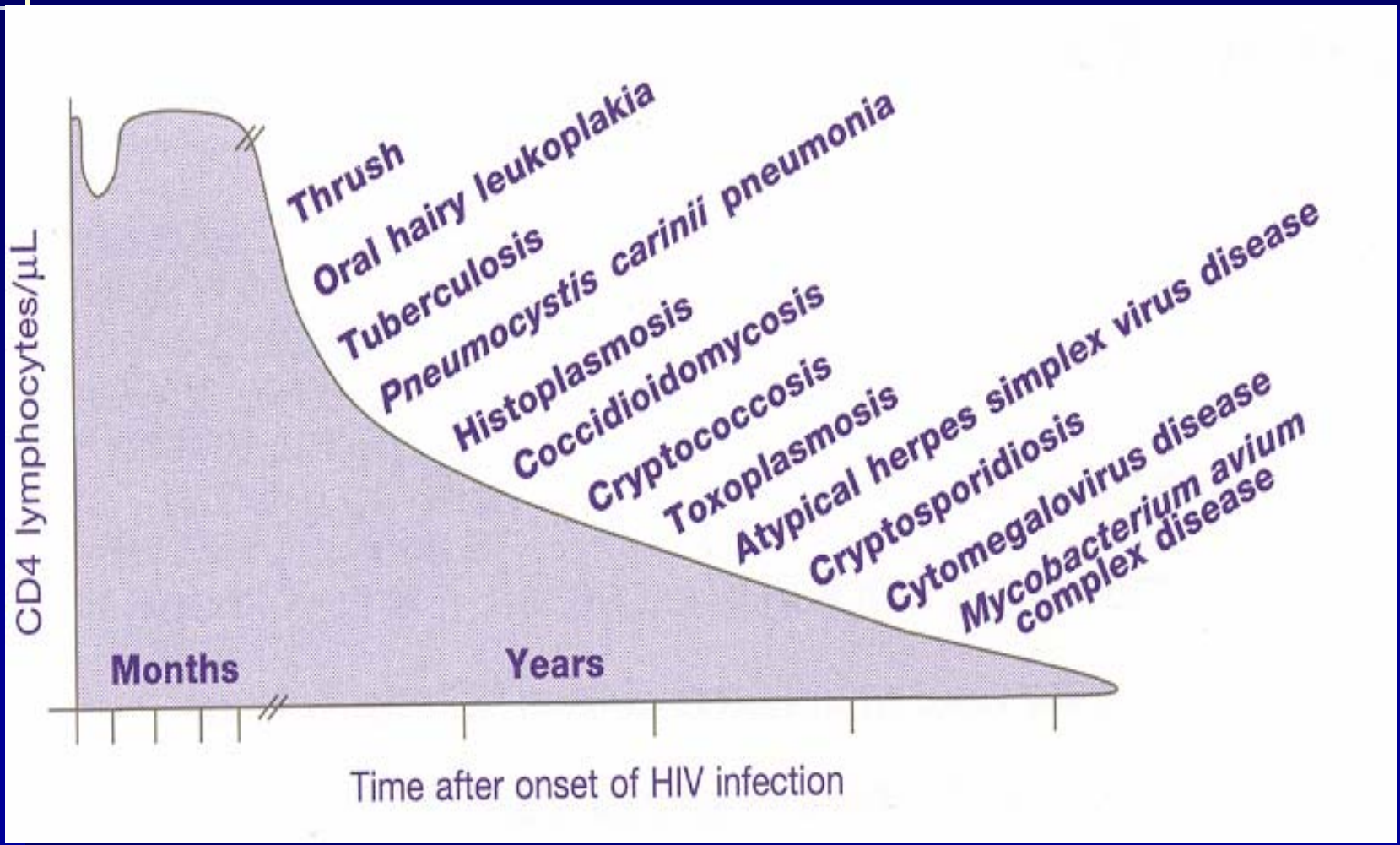
d) Non-nucleotide reverse transcriptase inhibitors (e.g., Tenofovir or Viread)

e) Membrane fusion inhibitors (e.g., enfuvirtide or T-20)

HIV/AIDS, treatment

- Highly active antiretroviral therapy (HAART)
  - Standard-3 drug regimen, monotherapy not effective
  - Clinical trials: non-detectable HVL in 80%
  - Non-adherence common due to side effects and complications, predicts treatment failure and viral resistance.
- Prophylaxis against opportunistic infections
  - Pneumocystis carinii pneumonia (PCP)
  - Toxoplasmosis
  - Mycobacterium avium complex (MAC)

Natural History of HIV Infection

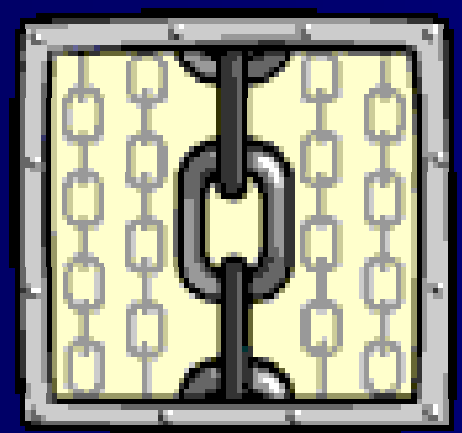


HIV/AIDS, support for monitoring

- HIV RNA (HVL, “viral load”)
  - Time of diagnosis and q 3-4 months
  - Before and again 2-8 weeks after initiation of antiretroviral therapy
  - Should be below detectable levels by 16-24 weeks
- CD4 count (“t cells”)
  - Time of diagnosis and q 3-6 months

HIV, symptomatic

- Weakness
- Neuropathy
- Nutrition/weight loss
- Dementia
- End of life care



HIV and opioid dependence, summary (also see TIP 37)

- Incidence high in needle users
- Viral load and CD4 count used for monitoring disease progression and deciding about treatment
- Treatment is lifelong, effective, difficult
- Adherence to treatment is key, resistance to drugs develops rapidly

Pain and MAT: (pp. 174-178, TIP 43)

Types of Pain

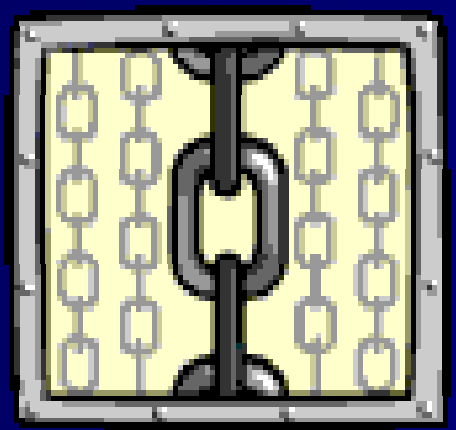
- Acute
  - Anticipated (Planned Surgery, Physiotherapy)
  - Unanticipated (Trauma, surgical emergency)
- Chronic
  - Stable
  - Progressive

WITHDRAWAL-MEDIATED PAIN:

- Withdrawal makes everything hurt, and what already hurts, hurts WORSE!!!
- Usually responds to a dose increase of single daily methadone.

Clinician most involved in chronic pain issues, (pp. 176-178, TIP 43)

- Dose recommendations
- Extent of function, improvement, assessment
- “coping” and “living with” pain support



Pain and politics

- Pain as the “fifth vital sign”
- Use of pain scales
- “intractable” pain
- “malignant” pain
- Painlessness as a civil right

Definitions

- Physical dependence on opiates
- Addiction to opiates
- Pseudo-addiction
- Abusability
- Prescription drug abuse

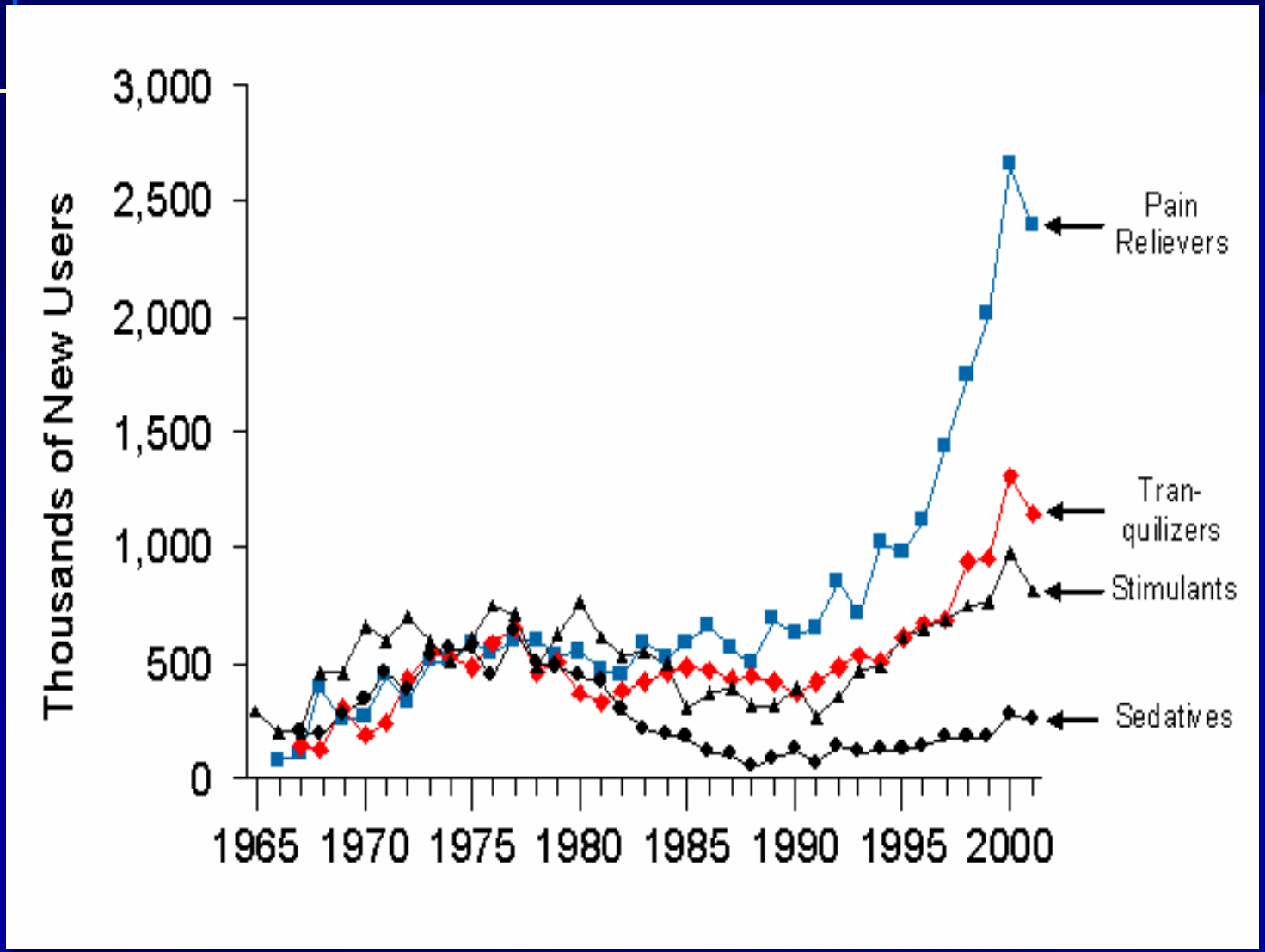
Commonly Abused Opioids

- Diacetylmorphine (Heroin)
- Hydromorphone (Dilaudid)
- Oxycodone (OxyContin, Percodan, Percocet, Tylox)
- Meperidine (Demerol)
- Hydrocodone (Lortab, Vicodin)

Commonly Abused Opioids *(continued)*

- Morphine (MS Contin, Oramorph)
- Fentanyl (Sublimaze)
- Propoxyphene (Darvon)
- Methadone (Dolophine)
- Codeine
- Opium

Number of new non-medical users of therapeutics



(NSDUH, 2002)

Treatment of chronic pain, principles.

- Often need short-acting, abusable opiates for intermittent pain increase
- Methadone as baseline, short-acting opiate as rescue, split dose.
- Avoid PRN dosing, don’t avoid opioids.
- Relapse is more often due to inadequate pain relief than too much narcotic

Chronic pain, psychological interventions, (p 177, TIP 43)

- Deep relaxation
- Biofeedback
- Guided imagery
- CBT
- Mood disorder treatment
- PTSD treatment
- Family/relationship therapy

(ref: Savage, 1998)

Addiction clinician's role, chronic pain

- Support adjustment
- Support psychosocial and non-pharmacologic treatment
- Recommend proper dosing of opiates if needed
- Monitor progress/control of pain

Disabilities, pp. 173-174

- Communication may need unusual arrangements.
- Home dosing may need creative solutions
- Counselor usually involved in case-management type activities
- Situations vary by clinic and community

Summary:

- MAT clinicians play a key role in managing medical problems
- Requires being up to date on the basics of usual treatment
- Requires links with resources
- Support of the patient and help in evaluating functional status are two main roles.